ENCLOSURE 1

PRIVACY ACT STATEMENT

AUTHORITY: Executive Order 13164; 29 U.S.C., Section 791, et. seq.; 42 U.S.C., Sections 12101, et. seq., 12201-12204, and 12210; 29 C.F.R., Part 1630.
PRINCIPAL PURPOSE(S): To collect personal information from an employee/applicant to assist with a request for reasonable accommodation and collection of required statistical data regarding requests for reasonable accommodation.
ROUTINE USE(S): To the Department of Defense and EEOC in instances where an employee/applicant requests a reasonable accommodation.
DISCLOSURE AND EFFECT ON THE INDIVIDUAL OF NOT PROVIDING INFORMATION: Voluntary; however, failure to provide the requested information may hinder the ability to provide a complete or adequate reasonable accommodation.

HEALTH AFFAIRS

CAP Office Use Only

Request #: _____ [ ] EFMP [ ] Flexi
Received:_____ [ ] DDESS [ ] WC
Completed:_____ [ ] DoDDS [ ] CTRS
Approved:_____ [ ] MTF [ ] DoD
Ordered: _____ [ ] Non-DoD [ ] State
Declined: _____ Canceled:_____
Vendor:_____Item Description:

CAP Accommodation Request Form

Complete this form to request assistive technology and services. Please ensure completion of all contact information. Approval is required from requester's supervisor. Signature certifies that the accommodation is necessary for a person with a disabling condition to accomplish an essential job requirement. Signature also verifies that the item requested becomes the property of the receiving Federal Agency. Furthermore, equipment maintenance beyond initial warranty period and additional supplies after receipt of equipment is the responsibility of the Federal agency. If you have any questions, please call CAP at 703-681-8813 (V) 703-681-0881 (TTY), or email CAP@tma.osd.mil.

Complete the form online at http://www.tricare.osd.mil/cap/requests/accommodation_req_form.cfm or you may fax completed form to 703-681-9075. You may also send by US Mail to:

DoD Computer/Electronic Accommodations Program Office
TRICARE Management Activity
5111 Leesburg Pike, Five Skyline Place, Suite 810
Falls Church, VA 22041-3206

1. NAME OF PERSON OR OFFICE TO BE ACCOMMODATED (PLEASE PRINT):

_____

Grade Level: _____ Occupational Series:_____ Are you a new federal employee?_____
Have you used CAP services before? [ ] Yes [ ] No
Please include your **CUSTOMER ID #** (if known)_____

2. ADDRESS/CONTACT INFORMATION: *(No P.O. Boxes - No acronyms)*

If your agency is within **DoD** (specify): _____
Organization: [ ] Army [ ] Navy [ ] Air Force
If your agency or department is **not** a DoD Agency (specify name): _____

DELIVERY ADDRESS:

Address1: _____
Address2: _____
City, State, Zip: _____
Telephone/TTY#: (please indicate which) _____
Fax #_____ Email Address: _____

3. DISABILITY INFORMATION: Identify your disability (Deaf/Hard of Hearing, Blind/Low Vision, Cognitive, Dexterity*: Additional information/medical documentation may be required to support the need of an accommodation per the Rehabilitation Act)

_____

Other (explain) _____
*Dexterity Disability (explain)_____
If you are a Workers' Compensation claimant, include your Workers' Compensation Claim # and copy of Department of Labor Claim Acceptance Letter:_____
If you are Flexiplace, include your agency agreement form.

Please fax supporting documents to 703-681-9075

4. SUPERVISOR/POINT OF CONTACT INFORMATION (Complete all fields):

Name (print): _____ Signature: _____

Telephone/TTY #: _____ Fax #: _____

Email: _____

✳ ✳ ✳ EQUIPMENT ✳ ✳ ✳

5. ITEM REQUESTED: Include brand name/model and attach any vendor information/brochures you may have. If requesting Speech Recognition Software, complete and fax the Speech Recognition Information Form, located under "News/Documents" on the CAP website.

_____

6. JUSTIFICATION: Please explain how this item will assist you in performing the essential functions of your job.

7. OPERATING SYSTEM: In order to establish compatibility, identify your computer operating system:

Win00___ Win98___ Win ME___ WinNT___ Win95___ Mac ___ Other___

8. EMPLOYEE SIGNATURE:_____

✳ ✳ ✳ FUNDED SERVICE ✳ ✳ ✳

Note: Complete this section only if you are requesting one of our funded services, which are: **Reader, Interpreter, or Personal Assistant.** A training session or travel must last two or more days. Submit **a fully completed request** at least **15** days prior to the start of the training or travel. Complete both sections A and B. Identify which funded service you are requesting from the list above_ _____

A. TRAINING SESSION:

Who is providing the training? (please check one) [ ] Private Company [ ] Government Agency

Training/Course Title: _____

Course Location: _____

Course Dates: _____Course Time: _____
Have you been officially registered for training? _____

B. INFORMATION ON SERVICE PROVIDER (INTERPRETERS, READERS, ETC.):

For interpreting service information refer to the CAP Interpreter Database, located under "Deaf Accommodation Services" on the website and for information on obtaining a personal assistant please refer to the CAP Personal Assistant Guidelines, located under "Documents" on the website.

Agency/Service Provider Name, Point of Contact and Address:

_____
Telephone/TTY #: _____ Fax #: _____
Cost/Quote (please attach): _____ Does service accept Credit Card Payment? _____
E-Mail: _____ Website: _____

Submitting this form signifies you agree to CAP terms and conditions.